

HYSTERECTOMY

Alternatives to Invasive Surgery

The solution to 'female problems' is not in resorting to unnecessary major surgery but in adopting safer, less invasive, more natural options which promote women's own self-healing powers.

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SOME STARTLING STATISTICS

At a meeting of the American College of Obstetrics and Gynecology in 1971, members hotly debated the issue of hysterectomy. The overwhelming conclusion regarding whether every woman who is finished with childbearing should have a hysterectomy was summed up by gynaecologist Ralph W. White, M.D. He expressed the members' prevailing attitude of respect for the female womb by proclaiming, "It's a useless, bleeding, symptom-producing, potential cancer-bearing organ."¹

It's unfortunate that such outdated views persist to the present day. When it comes to women and their reproductive organs, hysterectomy is usually the most popular solution for a range of "female problems". How popular?

In the USA, hysterectomy is the most common, major, non-obstetric procedure performed on women, with over 600,000 operations done each year, even though most of the "female problems" are medically trivial. (Caesareans are the most common obstetric procedure.) One out of three women will have had a "surgical menopause" before the age of 60—hysterectomy that includes removal of the ovaries. To date, about 20 million American women have had their uteruses removed. In Europe, the proportion is only one seventh of the US total, perhaps because medicine is socialised in several European countries and there is less of a profit motive.²

However, with the expectation of a huge number of baby boomers about to enter menopause, Dr Stanley West—noted infertility specialist, chief of reproductive endocrinology at St Vincent's Hospital, New York, and author of *Hysterectomy Hoax*—has predicted that the statistics will soon show that up to 60 per cent of women in the US will have a hysterectomy by the age of 60.

Hysterectomy rates in the United Kingdom continue to climb. Presently, about 100,000 women annually undergo this procedure. Some 43 per cent of hysterectomies involve the removal of one or both ovaries; and 60 per cent of those operations are performed on premenopausal women under the age of 49.³

In Australia, it is estimated that at least four out of every 10 women will have a hysterectomy by the time they turn 65. The Australian Institute of Health and Welfare has reported that the total number of hysterectomies performed in 1994-1995 was 36,817.

There are some locations in Australia that pose a greater risk for keeping female reproductive organs intact. John Archer, author of *Bad Medicine*, has noted that women in the Hunter region near Newcastle, NSW, had a 36 per cent higher chance of losing their uterus than others fortunate enough to live elsewhere.⁴ It seems that the hysterectomy option coincides more with the particular inclinations and surgical abilities of local gynaecologists rather than medical imperatives.

The percentage of hysterectomies which are truly necessary is subject to some debate. According to Dr West, "...more than 90 per cent of hysterectomies are unnecessary. Worse still, the surgery can have long-lasting physical, emotional and sexual consequences that may seriously undermine a woman's health and well-being."⁵ Many authorities agree, however, that 90 per cent of the procedures are "elective", that there are alternatives in at least 90 per cent of cases, and that less than 10 per cent of the operations are in fact medically necessary.

Of the 110,000 women counselled by the Pennsylvania-based Hysterectomy Education and Research Services (HERS) Foundation and referred to board-certified gynaecologists for second opinions regarding a recommended hysterectomy, 98 per cent of them discovered they did not need hysterectomies after all.

WHAT IS HYSTERECTOMY?

Hysterectomy is, by definition, the removal of a vital female organ, the uterus. Sometimes the ovaries, Fallopian tubes and cervix are removed along with the uterus.

Technically, hysterectomy refers only to the removal of the uterus, while a "bilateral salpingo-oophorectomy" is the removal of the ovaries and Fallopian tubes. However, it is now common for both doctors and women to use the term "total hysterectomy" to describe the removal of the uterus, ovaries, Fallopian tubes and part of the cervix.

The majority of hysterectomies are performed on women between the ages of 20 and 49. In the US, 76.4% of hysterectomies are done on women in this age group.⁶ When undergoing hysterectomy, the older the woman is, the more the likelihood that she will have her ovaries removed. The removal of a woman's ovaries is described as "surgical menopause". It creates a radical physiological and psychological change in a woman.

Hysterectomy is major surgery, usually done in a hospital under general anaesthesia. Typically, women are hospitalised for several days and are generally told that it will take anywhere from six weeks to three months to recover. However, most women say recovery takes almost a year, and some spend many more years tinkering with their hormones in an attempt to feel normal again.

RATIONALE FOR SURGERY

Hysterectomy is offered as a treatment for several conditions. In the US, the leading cause for surgery is uterine fibroids—benign growths that, while sometimes troublesome and painful, are not life-threatening. Fibroids account for about 30 per cent of all hysterectomies. Endometriosis is ranked second and is the reason for about 24 per cent of all hysterectomies. The third-ranking indication is prolapse, the sagging of the uterus into the vagina due to loosening of the muscular supports that hold it in place. Prolapse accounts for about 20 per cent of hysterectomies, and approximately one-third of these operations are performed on women past the age of 55. Endometrial hyperplasia (abnormal proliferation of cells in the endometrium due to excessive oestrogen stimulation) ranks fourth and accounts for six per cent of hysterectomies. The remaining 20 per cent include menstrual disorders, ovarian cysts and pelvic inflammatory disease.⁷

The Australian statistics are similar, with fibroids accounting for 22 per cent of hysterectomies; endometriosis, 6-23 per cent; heavy menstrual bleeding, 18 per cent; prolapse, 7-23 per cent; cancer, 1-12 per cent; and pelvic inflammatory disease, 2-8 per cent. Multiple reasons are given for the remainder.⁸

Dr Stanley West, an outspoken critic of the gynaecology profession's unwarranted enthusiasm for hysterectomy, states that only 10 per cent of all hysterectomies are performed to remove cancer. He warns women that unless cancer is positively identified, it is unlikely that hysterectomy is required, and that they should be very sure that cancer has been found before consenting to the surgery. He says that, "Chances are you are in the 90 per cent, not the 10 per cent [and] even women with cancer of the endometrium, ovaries and cervix may have some options..."⁹ According to Dr West, the only 100-per-cent-appropriate reason for performing hysterectomy is to remove cancer of the reproductive organs.

However, according to Dr West, "...the consequences of losing your ovaries cannot be overstated. Premenopausal women will undergo an 'instant' menopause, complete with symptoms that are far more severe than those that accompany normal menopause which follows a gradual decline in hormone production. The rationale for removing the ovaries during hysterectomy is to prevent ovarian cancer, a terrible disease that is often deadly because it cannot be diagnosed early. But statistically, a woman who has had a hysterectomy is at no higher risk for ovarian cancer than a woman who has not had surgery. ...without her ovaries a woman will forever be at higher-than-normal risk for both osteoporosis and heart disease, both of which represent a far greater statistical threat than ovarian cancer."¹⁰

Dr West told me in a recent phone conversation that there is still some risk of ovarian cancer even if the ovaries are removed because some ovarian tissue may remain in place in that area; thus it is impossible to eliminate the danger completely.

SURGICAL PROCEDURES AND COMPLICATIONS

Technically, hysterectomy is a fairly simple operation that involves detaching the uterus from the blood vessels and the ligaments that support it. Since it is such a straightforward procedure, it should be a safe operation. However, nothing could be further from the truth.

Fifty per cent of all patients develop complications from hysterectomy surgery—some of them quite serious.¹¹ Many of these complications are the preventable outcome of sloppy surgery and may involve damage to the bladder, bowel and ureter. Postoperative bleeding can lead to fatal haemorrhaging, and an alarming statistic is that one out of 1,000 hysterectomy patients will die.

There are three surgical approaches to hysterectomy. Abdominal hysterectomy, the most

common method, requires an eight-inch incision across the lower abdomen, just above the pubic hairline, to remove the womb (and/or ovaries) through the abdominal wall.

Vaginal procedures comprise about 20 per cent of hysterectomies. Instead of opening the abdomen, the surgeon approaches the uterus through the vagina, detaches it and pulls it out. The severed tissues are drawn out through the vagina and the wound is sutured internally using a minute stitching gun.

The newest approach to hysterectomy involves the use of a viewing device called a laparoscope, which is inserted via a tiny abdominal incision near the navel. Other surgical instruments are inserted through similarly small incisions. Any organs to be removed, such as the uterus, ovaries or tubes, are detached and pulled out through the vagina. The main advantage of laparoscopic surgery of any type is that a small incision means a shorter hospital stay (one to four days), less pain and more rapid recovery. Because laparoscopic surgery involves less physical strain than conventional surgery, it has become very popular, although it is more expensive than abdominal surgery. Unfortunately, however, not all surgeons are as proficient as they should be before attempting this procedure, thus increasing the incidence of botched operations and surgical mutilation.

There is considerable risk of surgical complications arising from hysterectomy. These complications include:

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• **Adhesions:** These are internal scars that develop when tissue surfaces stick together after surgery. As a general rule, because blood contains a sticky component that causes tissues to adhere, any type of bleeding can lead to adhesions. During surgery, adhesions present a risk of injury to a structure that is stuck to the organ being removed. With hysterectomy, the organs most likely to be adhered to the uterus are the bladder and bowel. There is always the danger that new adhesions will develop as a result of surgery. This is most likely to happen when the surgeon does not find and suture all bleeding surfaces. These new adhesions could complicate any future surgery and/or lead to an intestinal obstruction years after surgery.

• **Bowel Injury:** If the bowel is accidentally cut, clamped or sutured in the course of surgery, the intestinal contents can spill into the abdominal cavity, causing infection of the peritoneum, the transparent, cellophane-like sac that surrounds the abdominal organs. The infection peritonitis can be quite serious and even fatal if not checked. More than twice as many hysterectomised as non-hysterectomised women have problems not only with bowel function (chronic constipation) but with urinary frequency.

• **Bladder Injury:** A bladder injury is easily corrected during the operation if the surgeon recognises that the bladder has been cut. If not, there will be a risk of peritonitis. If the injury results in a fistula (opening) between the bladder and vagina, urine will leak uncontrollably into the vagina. Bladder repair must be performed surgically.

• **Injury to Ureter:** The ureter is the tube connecting the kidney to the bladder. Located next to the cervix, it can be damaged easily. If the ureter is nicked, sewn or kinked during surgery, the outflow of urine from the kidney to the bladder will be blocked, leading to possible kidney damage. Corrective surgery will then be needed.

• **Postoperative Bleeding:** Such bleeding usually stems from a surgeon's failure to secure the major artery, which may lead to haemorrhaging that could be fatal. Surgery will be needed to secure the artery. Oozing blood causes adhesions to form.

• **Infection and Fever:** With vaginal hysterectomy there is a higher risk of vaginal infection because of exposure to bacteria.

POST-HYSTERECTOMY SYNDROME

The after-effects of hysterectomy are most dramatic. With the removal of the ovaries, surgical menopause is initiated, causing more severe symptoms. In a relatively short period of time, a woman may experience fatigue, insomnia, urinary problems, headaches, dizziness, vertigo, nervousness, irritability, anxiety, heart palpitations, joint pain, weight gain, vaginal dryness, diminished physical strength, difficult or painful sexual intercourse, hair loss and a variety of skin problems.

British researcher D. H. Roberts, M.D., examined the after-effects of hysterectomy. He found that hysterectomy was much more likely to lead to postoperative physical and psychological problems described as "post-hysterectomy syndrome". These symptoms included depression, hot flushes, urinary problems and extreme postoperative fatigue. One or more of these symptoms was found among 70 per cent of the patients participating in his study, which was published in the *Lancet* in 1971.

The incidence of post-hysterectomy depression appears to be relatively widespread. Dr Susan Love states that some 30 to 50

per cent of women suffer from depression, but other researchers estimate the percentage to be as high as 70 per cent. For some it is minor and shortlived, while for others it becomes a chronic state. Other psychological disturbances include mood change, anxiety and irritability. While there is no doubt that feelings of grief can be brought on from a woman's sense of loss of her womb and the accompanying mourning process, there are also biochemical reasons for this depression.

The hormonal disruptions brought on by the surgery can be far-reaching, affecting the nerve and hormone (neuroendocrine) interactions responsible for the sense of emotional well-being. Hormonal disruption affects substances called "beta endorphins" which are associated with feelings of well-being. Recent research shows that endorphin levels are influenced by a change in levels of the ovarian hormones oestrogen and progesterone. A study at Columbia University showed that oestrogen acts to stimulate release of endorphins from the hypothalamus. This may explain why depression develops when the ovaries are removed or if they cease to function after menopause.¹²

Another troubling problem still to be accounted for is an increased risk of heart disease after hysterectomy. The risk of heart disease is greatest when the ovaries are also removed. In

addition, some data indicate that women who have their ovaries removed have higher rates of osteoporosis, even when taking hormone therapy.¹³

Since the uterus is the key pelvic organ holding other organs in place in the pelvic cavity, with its removal there is a tendency for the bowel and bladder to prolapse into the open cavity, leading to an eventual prolapse into the vagina. It is also reported that after surgery the hip bones tend to widen, causing prob-

lems in the entire pelvic area as well as in the back, legs and feet.

The medical profession continues to reassure women that their uteruses are disposable organs that they can quite happily live without.

IMPORTANCE OF THE UTERUS

The medical profession continues to reassure women that their uteruses are disposable organs that they can quite happily live without. In fact, the uterus-free woman is depicted as a carefree individual released from the drudgery of uncomfortable and debilitating female problems. An editorial published in the prestigious British medical journal *Lancet* (15 August 1987) has no doubt played an important part in lulling doctors and women into such a false sense of security about hysterectomy when it stated:

"...for the woman who is not interested in having children, or whose family is complete, this solution [hysterectomy] is often attractive... [It promises] relief from her symptoms and other expected benefits—greater reliability at work, availability at all times for sexual intercourse, saving on sanitary protection, freedom from pregnancy and freedom from uterine cancer."¹⁴

To appreciate just how ludicrous such statements are, it is necessary to have some basic understanding of the female reproductive system. The uterus, or the womb as it is also known, is a muscular organ designed for childbearing. Far from being a disposable organ that serves no further purpose when the childbearing days are over, the uterus is the main site for the production of the hormone prostacyclin which protects women from heart disease and unwanted blood-clotting. Since prostacyclin cannot be synthetically manufactured in a laboratory, the removal of the uterus will ensure its production will cease forever.¹⁵

The uterus also is an important sex organ. The groundbreaking research by Masters and Johnson on human sexuality revealed that the accelerating pitch of sexual excitement prompts the uterus to contract and rise out of the vagina. At orgasm, it undergoes a series of contractions. All the other so-called orgasms—of the vagina, clitoris and nipples—are the initiators of sexual excitement but Masters and Johnson showed that uterine contractions are the end point of this excitement and that female orgasm requires these contractions.¹⁶

As a result of hysterectomy, some of the nerves connected to the uterus are severed; but these nerves also supply parts of the abdomen, the clitoris and the upper thigh, so this can lead to a loss of tactile sensation from the waist to the mid-thigh region.

Given these findings, there is no doubt that the sexual changes women report after hysterectomy are real, not imagined. Evidence suggests that without a uterus there can be no orgasm. Other researchers have also shown that internally induced orgasm occurs when the penis presses hard and repetitively against the cervix, causing movement of the uterus and its supports. (It is also common for the cervix to be removed during a hysterectomy as a so-called preventive measure against cervical cancer.)

There is another function of the uterus that is usually not given much credence by the medical profession but is nonetheless an important one. According to Christiane Northrup, M.D., author of *Women's Bodies, Women's Wisdom*, "The uterus is related to a woman's innermost sense of self and her inner worlds. It is symbolic of her dreams and the selves to which she would like to give birth [and] reflects her inner emotional reality and her belief in herself at the deepest level."¹⁷ The uterus is the centre of a woman's creative self.

OVARIES' LIFELONG ROLE

Aside from the ovaries' important function of storing and maturing the eggs, they have another important role as endocrine glands, producing hormones before, during and after menopause.

Far from the popular myth that ovaries dry out, shrivel up and become completely useless at menopause, the ovaries perform a vital function during a woman's entire postmenopausal life. As women naturally age, a part of the ovary—the theca, the outer covering where the eggs grow and develop—does shrink; but the inner part of the ovary, the inner stroma, actually becomes active at menopause for the first time in a woman's life.

After menopause the ovaries continue to function, working in concert with the skin, liver and fat to produce hormones. Celso Ramón García, M.D., director of surgery at the Hospital of the University of Pennsylvania, USA, is one of many authorities saying that the hormones produced by the postmenopausal ovaries promote bone health and skin suppleness, support sexual functioning, protect against heart disease and contribute to a woman's health and well-being.¹⁸

The ovaries serve more than one purpose. Reproduction is their most dramatic function but it isn't the only one. These organs have as much to do with the maintenance of a woman's own life as they do with her role in bringing other lives into the world. The menopausal ovary is neither failing nor useless. At menopause it is simply beginning to shift from its reproductive to its maintenance function.

The removal of the ovaries is a great trauma to a woman's body at any age. Since the ovaries are the primary site of a woman's hormone production, surgically removing them immediately puts her into an instant menopause. The effect is so immediate that some doctors put an oestrogen patch on the patient while she is still in the operating theatre. Many women have severe hot flushes within two hours after surgery. Unfortunately, oestrogen therapy doesn't always compensate for the missing hormones since the ovaries make more than just oestrogen. When you lose your ovaries, you also lose progesterone, some of your testosterone and androstenedione (a form of androgen which is an oestrogen precursor), as well as any other hormone the uterus and ovaries might make, of which medical science is as yet unaware.¹⁹

The removal of the ovaries, whether or not hormone therapy is taken, makes a woman more vulnerable to osteoporosis and heart disease than a woman who experiences natural menopause, probably because the body needs more than just oestrogen. The idea that oestrogen therapy can 'replace' the work of the lost ovaries is misleading, and new data on the other hormones produced by the ovaries shows that it can't. Women who have their ovaries removed don't feel normal when only oestrogen is 'replaced'. This may relate to orgasm, libido and general well-being.

The female reproductive system is still very much shrouded in mystery and by no means fully understood by medical science. Dr Susan Love postulates that, "...the earlier menopause caused

by ordinary hysterectomy (removing only the uterus) suggests that there may be a connection we haven't yet discovered between the uterus and ovaries—something akin to, or part of, the feedback loop of the brain, hypothalamus, pituitary and ovary. The uterus may produce a hormone that responds to the ovary. Then when the uterus is gone and the feedback ends, the ovary realises it doesn't have any place to drop its eggs, so it stops trying."²⁰

Dr West concurs. "Even when the ovaries are left in place, many women develop serious physical and emotional

problems. Most are due to permanent ovarian failure. In up to 50 per cent of women whose ovaries have been left intact, the ovaries often cease to function normally after hysterectomy. ...we can assume that at least 70 per cent of all women who have hysterectomies will encounter some problems."²¹

MEDICAL SCIENCE OR MISOGYNY?

The uterus is the female equivalent of the prostate gland, while the ovaries' counterparts are the testicles. The removal of the prostate and testicles results in castration for a man. But for a woman, when her uterus and ovaries are removed, she, too, is effectively 'castrated'.

No doctor in his/her right mind would suggest to a man that he have his prostate and testicles cut out unless his life were seriously endangered, nor make absurd statements promising him a new and better life. Yet, gynaecologists are all too eager to suggest this serious procedure to women for many minor and certainly less-than-life-threatening complaints.

No physician today can assure any woman that hysterectomy will not affect her sex life. Dr West warns that it is therefore imperative for women to understand that their uteruses and/or ovaries should not be willingly sacrificed except for the purpose of saving life.

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Even though it is known that hysterectomy has a profound physiological and psychological impact on a woman's life, why has it become the most popular non-obstetric procedure performed on women? In order to understand this anomaly, it is essential to understand the historical roots of medical science and gynaecology in particular.

The Greeks invented the word *hysterikos* to explain "suffering caused by the uterus" (*hystera* = womb), which they believed included just about any physical or psychological malady imaginable. Hippocrates himself asked the question, "What is woman?", and answered it in just one word: "Disease."

By the 17th century, Christianity had embraced the notion that whatever was 'wrong' with women—and this encompassed such non-medical 'problems' as sinfulness, sexuality and emotionalism—was due to the reproductive organs they carried within them. Two centuries later, when modern medicine was in its unscientific infancy, physicians fixed on the uterus as the source of just about every complaint a woman might voice.

The 'science' of gynaecology 'blossomed' in the mid-Victorian era when attitudes to women were, at their most bizarre, a curious mixture of contempt and idealism. Women were thought of as pale, delicate flowers who wilted easily and required great care, even in small matters—and preferably under medical supervision.

It was also around this time that women were 'proven' to be intellectually inferior to men. According to the popular 19th-century physician and medical philosopher, Charles Meigs, women's heads were almost too small for intellect but just big enough for love.²² The prevailing theory cautioned women against developing their intellect since it would cause the uterus to atrophy! 'Scientific studies' published in the 1860s demonstrated that while blacks had smaller brains than whites, women had even smaller brains than black men!

Gynaecology's early ignoble beginnings can be attributed to James Marion Sims, who became widely known as the "father of gynaecology". In the 1840s, Sims practised in the southern US state of Alabama and began to experiment on Negro slaves. According to Sheila Kitzinger, "This man was able legally to take possession of black women's bodies and perform surgery on them at will. He actually bought some of the subjects for his experiments. One woman endured thirty sessions of surgery without anaesthesia before Sims was satisfied with the job he had done. Sims became a hero for generations of obstetrician gynaecologists who followed him, many dreaming of worldwide fame."²³

The concept of the uterus as a 'dominant organ' controlling women's behaviour has obsessed gynaecologists for more than a century. They considered that conditions such as hysterical mania, nymphomania, depression and even the "uncontrollable urge to waltz" could be cured simply by removing the cause: the uterus. This left the woman passive, happy and relieved of "the cause of menstruation".²⁴

In the years that followed the introduction of anaesthesia, a woman was likely to find herself on the operating table for just about anything her husband, father or doctor might decide was wrong with her: overeating, painful menstruation, attempted suicide and, most particularly, masturbation, erotic tendencies or promiscuity. The doctors of the day were convinced—and managed to persuade their patients—that hysterectomy had a calming

effect that would render women more "tractable, orderly, industrious and cleanly".²⁵

Given all those centuries of misinformation about the female body, it is small wonder that so many of today's doctors continue to view the uterus as a troublesome, disposable organ. An extract from a 1987 public information booklet on hysterectomy, produced by the Royal Australian College of Obstetricians and Gynaecologists, reassuringly states:

"Women who have had an hysterectomy are delighted with the result. No longer do they have to plan their lives around their heavy or painful periods. No longer being anaemic, they gain fresh energy and life is fuller and happier than it may have been for years."²⁶

THE HIGH COST OF A GYNAECOLOGIST

It would be naïve to think that the popularity of hysterectomies wasn't in some way related to the financial rewards for gynaecologists. For example, Australian obstetricians and gynaecologists perform a great deal of surgery and earn higher incomes than physicians, surgeons or medical practitioners. In 1991-92 the overall average annual income for full-time obstetricians and gynaecologists was A\$320,000 p.a., with at least 25 per cent of them earning more than \$550,000 annually from private patients alone. Added to this is income derived from sessional work pub-

lic patients—often between \$100,000 and \$200,000 p.a.²⁷

In the US, gynaecologists, hospitals and drug companies make more than US\$4 billion a year from the hysterectomy and castration business.

In 1994, Dr West wrote of attending a seminar on medical economics: "The topic was how to care for women in order to maximise our fee. The experts who led the discussion reminded us that gynaecologists make the most money by doing surgery and that the highest fee we can generate

comes from hysterectomy. With that in mind, we were urged to 'cultivate' our patients carefully. Initially, care would require advice on contraception. Then, in the normal course of events, we would supervise their pregnancies and deliver their babies. Once a patient had completed her family, we were advised to plant the idea that she might some day need a hysterectomy. The culmination of our years of care would be the hysterectomy. With proper planning, our advisers suggested, each year of practice would produce a lucrative 'crop' of women ripe for hysterectomy."²⁸

SAFER ALTERNATIVES TO HYSTERECTOMY

The removal of so many uteruses and ovaries would be more understandable if there were no alternatives available to deal with the problems for which the operation is performed. Fortunately there are. In fact, it is stunning how often dietary, nutritional and emotional/spiritual approaches can heal many of the problems. In many cases there are alternative procedures that, while far less drastic, are just as successful:

Fibroids: Fibroids are the primary reason why women in their 30s and 40s are recommended hysterectomies, and they occur in some 30 to 50 per cent of women. Fibroids are benign, non-cancerous lumps of the muscular wall of the uterus, composed of smooth muscle and connective tissue. They are rarely solitary and never life-threatening, although at times they can become uncomfortable and problematic. Most, however, cause no prob-

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lems and shrink at menopause when oestrogen levels decrease. Fibroids are a product of oestrogen dominance: oestrogen stimulates their growth, and lack of oestrogen causes them to atrophy.

Dr John Lee, author of *What Your Doctor May Not Tell You About Menopause*, has successfully stopped the growth of fibroids and, in some cases, eliminated them completely by using natural progesterone creams that counter the oestrogen dominance effect.

Changes to diet are also quite effective. Dr Christiane Northrup has found that, "A woman who [adopts] a low-fat, high-fibre, mostly vegetarian diet will often experience decreased bleeding, bloating and even a decrease in the size of her fibroids." The diet she recommends eliminates dairy products, red meat, chicken and refined sugar. She advises eating organically grown food as much as possible to eliminate the oestrogenic effects from pesticides and herbicides. Dr Northrup also reports that, "The vast majority of women who treat fibroids through diet get rid of their pain and heavy bleeding within three to six months."²⁹

Surgery is usually only appropriate when women have heavy bleeding or pain that cannot be alleviated in any other way; if they want to become pregnant but fibroids are a significant hindrance; or if the fibroids are interfering with the function of other organs. Even when surgery is required, however, there is usually a better choice than hysterectomy. A procedure called "myomectomy", which removes the fibroids while leaving the uterus intact, does not cause the multitude of problems and symptoms associated with post-hysterectomy syndrome. However, myomectomies require greater skill on the part of the surgeon.

Endometriosis: The second most common problem used to justify hysterectomy is endometriosis, a condition in which tiny islets of endometrium (inner lining cells of the uterus) become scattered in areas where they don't belong, e.g., the Fallopian tubes, within the uterine musculature, on the outer surfaces of the uterus and other pelvic organs, the colon, bladder and sides of the pelvic cavity.

While the cause of endometriosis is unclear, there is no doubt that it is a disease of the latter part of the 20th century since it was virtually unknown earlier this century. Dr John Lee speculates that this disease has been spawned as a result of xeno-oestrogen (toxic oestrogens found in pesticides and herbicides) prevalence in the environment.³⁰ He notes that 70 years ago there were 21 cases of endometriosis worldwide, but, in stark contrast, a total of five million cases have been reported to date in the US alone.

Endometriosis symptoms include incapacitating menstrual cramps, heavy bleeding, nausea and vomiting. While drug treatments using synthetic progestins are available, they have side-effects and in the end don't always provide relief. Hysterectomies are often performed on women after the drugs have failed.

Unfortunately, surgery does not always alleviate the pain and difficulties. Endometriosis, being aggravated by oestrogen excess, will disappear with menopause.

Dietary changes greatly assist in reducing the symptoms of endometriosis. As Dr Northrup reports, "Endometriosis symptoms often disappear completely or lessen dramatically when women follow a low-fat, high-fibre diet free of all dairy products (even low-fat dairy products)."³¹

Dr Lee has achieved successful results using natural progesterone cream to treat women with endometriosis. He writes that,

"Since oestrogen initiates endometrial cell proliferation and the formation of blood vessel accumulation in the endometrium, the aim of treatment is to block this monthly oestrogen stimulus to the aberrant endometrial islets. Progesterone stops further proliferation of endometrial cells [but] the treatment requires patience..."³²

Pelvic Pain: Sometimes women experience chronic pelvic pain, with no diagnosable pathology able to be found. While hysterectomies are often performed under these circumstances, they fail to relieve the pain in 30 per cent of cases. However, women have received benefit from using a combination of correct diet, exercise, natural progesterone, nutritional supplements and emotional exploration.

Menstruation: Unfortunately, some doctors still regard menstruation as something of a disease, to be treated by removal of the uterus. Novak's *Textbook of Gynecology*, a widely used textbook in the 1970s, instructs:

"Menstruation is a nuisance to most women, and if this can be abolished without impairing ovarian function, it would probably be a blessing not only to the woman but to her husband... Thus one can make a rather convincing case for the value of elective hysterectomy."³³

Women suffering from menstrual irregularities and heavy bleeding have found great benefit from using a range of natural therapies, by making dietary and nutritional changes, and by adopting meditation and relaxation techniques.

Cancer: Removal of the reproductive organs is clearly justified and has saved many lives when cancers have developed in these organs. Yet, pre-cancerous changes in the uterus or cervix are often used to justify hysterectomy. This is unfortunate, because the vast majority of these changes can be arrested and reversed without major surgery and before becoming cancerous.

WOMEN'S RIGHTFUL POWERS

There is no doubt that there are valid and justified reasons for undergoing hysterectomy and that many women who have been suffering from chronic, painful and sometimes life-threatening conditions have indeed benefited immensely from surgery. It is crucial, however, that every woman should know exactly what she is getting herself into. After all, it's impossible just to pluck out an organ or disturb the body's balance without paying a price.

For those women who have already undergone hysterectomy, it may be distressful to realise that the surgery may well have been unnecessary. Though nothing can bring back a uterus that has been removed, it can be healing, even years after surgery, to take a quiet moment, place your hands on your belly, thank your uterus for all it gave you and say goodbye. By choosing a healthy diet and lifestyle, and considering guidance from qualified natural practitioners or complementary medicine doctors, a woman is better able to ensure and maintain her health and well-being.

Perhaps the best advice comes from Dr Stanley West:

"The challenge informed women face is to persuade doctors to turn away from the panaceas of the past to the treatments of the future. The last few decades have shown how forceful and resourceful women can be in pursuit of the economic and political power they were so long denied.

It is crucial, however, that every woman should know exactly what she is getting herself into.

...it's impossible just to pluck out an organ or disturb the body's balance without paying a price.

Continued on page 83

Continued from page 34

"Just as basic to full autonomy is control of your body and the right to make decisions about your health and health care on the basis of all available information, free from pressure, scare tactics and outdated doctor-knows-best paternalism. It is time we doctors stopped disassembling healthy women. But nothing will change until more women look their doctors in the eye and calmly state their determination to remain intact women."³⁴

Endnotes

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32. Lee, op. cit., p. 242.
33. Robbins, op. cit., p. 132.
34. West, op. cit., p. 189.

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- **UK:** Campaign Against Hysterectomy and Unnecessary Operations on Women, PO Box 300, Woking, Surrey GU22 0YE, England; phone 01483 715435.
- **USA:** Hysterectomy Education and Research Services (HERS) Foundation, 422 Bryn Mawr Avenue, Bala Cynwyd, PA 19004; phone (610) 667 7757 (telephone consultations offered), fax (610) 667 8096; e-mail, HERSFdn@aol.com; web, <http://www.dca.net/~hers/>

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